cytology or colposcopy exams may be indicated during pregnancy for patients with squamous intraepithelial lesions. Abnormal cytology in pregnancy should also be followed up with additional colposcopy postpartum.

- **Diabetes screening**: Type II diabetes mellitus is endemic in the Native American population. Native American ethnicity is a sufficient risk factor to justify screening all American Indian and Alaska Native women between 24 and 28 weeks of gestation. Moreover, as ACOG states, "...in certain Native American populations, the prevalence of gestational diabetes mellitus is so high that pregnant women in these populations can be considered to have a positive screen. They may proceed directly to diagnostic testing."[18]

Screening Methods in Pregnancy

- *Screening:* 50-g glucose load given at random. A 1-hour postload plasma glucose determination of 140 mg/dL or higher requires an oral glucose tolerance test.
- *Diagnosis:* 3-hour oral glucose tolerance test using 100 g glucose after overnight fasting.

Upper limits of normal in pregnancy:[19]

Fasting: 105 mg/dL (plasma)

1-hour: 190 mg/dL

2-hour: 165 mg/dL

3-hour: 145 mg/dL

It is IHS policy to screen all gravidas at 26-28 weeks unless risk factors for diabetes are identified at the first prenatal visit, which then would require earlier screening and diagnosis. In some centers, patients are also routinely screened at the first prenatal visit, and then again at 26-28 weeks.

Additionally, there are several recent reports that stress the importance of good diabetes control prior to conception and during early pregnancy. The risk of major congenital anomalies is significantly reduced in the infants of diabetic women who have normal HbAlc values as opposed to those with poorly controlled diabetes who have elevated levels.[20,21]

GENETIC COUNSELING

All prenatal patients should be screened early in pregnancy for a history of previous children with, or family history of, inherited disorders or other congenital anomalies. Appropriate genetic counseling should be made available either directly or through referral.

All women who present prior to 20 weeks of gestation should be offered screening for open NTDs and Down syndrome.[22] Those who will be under age 35 years at delivery should be offered a maternal serum alpha fetoprotein test (MSAFP) to screen for open NTDs and MSAFP with the addition of serum hCG and serum estriol as multiple-marker screening for Down syndrome. Women who will be 35 years or older at the time of delivery should be offered genetic amniocentesis, as they are considered to have a positive screen for Down syndrome on the basis of age alone. This testing should be preceded by culturally appropriate counseling that includes a discussion of the incidence and consequences of Down syndrome and open NTDs, the risks of false-positive tests, and the nature of the work-up for a positive test. These tests are screening tests, and, as such, the likelihood that a positive multiple-marker screen will predict Down syndrome or that a positive MSAFP will predict an NTD are small. They identify women at risk; definitive diagnoses are based ultimately on amniocentesis. Counseling should also include discussion of options should a positive diagnosis be made, as antenatal treatment is not available. Abortion, if elected, cannot be funded with federal dollars. (See Chapter C for further discussion.)